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AUTHOR LaGana, Christine M.; And Others
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ABSTRACT

This report focuses on the development of a behavior modification program to help institutionalized patients prepare for situations they may encounter after discharge from the hospital. The rationale for this program is explained in terms of the severe differences that exist between life in a mental institution and community life. A daily program that teaches skills such as anger management, relaxation techniques, use of community facilities, personal care, and homemaking skills are described along with program goals and reinforcements. Evaluation data of the program are provided, indicating that of the first 20 patients discharged from the program, the readmission rate was 5% compared to a 41% readmission rate for non-program discharges. A schedule of daily activities in the Social Learning Unit and Point Sheets are also included. (Author/JAC)

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Deinstitutionalization as a Goal of Behavior Modification: A Preliminary Report

Christine M. LaGana, Ph.D.
Canandaigua V.A. Medical Center

Frank Williams, MSW
Canandaigua V.A. Medical Center

Sherry Sacco, RN
Canandaigua V.A. Medical Center

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DEINSTITUTIONALIZATION AS A GOAL OF BEHAVIOR MODIFICATION : A PRELIMINARY REPORT

Care of chronic mental patients is changing. Large residential institutions historically have isolated persons with emotional or mental problems from the rest of society. Now, hospitals have been emptying their wards and sending their former residents out to make lives for themselves in the communities.

These shifts away from institutionalized treatment are based on changes that have taken place in the experiences of mental health professionals, in medical research and in civil rights movements. Psychiatrists, psychologists, social workers and nurses question the benefits of the institutional setting for mental patients. Is living among disabled persons in a hospital an aid to restoring the mental equilibrim of a patient? Many professionals think not. Chemical research has produced drugs that often reduce or eradicate the overt symptoms for which the patients were hospitalized. Thereby treatment in the community is viable. From a civil rights standpoint a patient should not be institutionalized unless he poses a danger to himself or others.

In many cases the placement of patients outside the walls that formerly gave them shelter has meant little more than finding them quarters in rooms, boarding homes or inexpensive hotels where they receive room and board and sometimes a little recreation. It has become evident that simply "releasing" mental patients does little to improve their situation. Post - hospitalized, handicapped persons require special help and support to become re-established in society. They need assistance in finding - maintaining a suitable place to live, an appropriate job and adequate social life. They need assistance in redeveloping the life management skills required for this "community reentry". Otherwise, rehospitalization is imminent and the cycle becomes chronic.

At a 1000 bed Veteran's Administration Neuropsychiatric Medical Center in upstate New York, a highly structured behavioral focus has been used to help prepare patients for the situations they will encounter after discharge. The program is based on a Skills Training model with a focus on the responsibility of the patient for his own care. Current literature suggests that skills training is useful in improving interpersonal functioning and life management skills which, in turn, leads to more positive interaction with the environment and increases the likelihood that the individual will require less full - time hospital care. The rationale for this program lies in the severe differences which exist between life in a mental institution and life in the Community. With the exception of referral for Day Treatment Center activities, to which many patients fail to return, there is essentially little or no transitional period where the patient may relearn (or learn, as the case may well be) such self-care skills as housekeeping, time-structuring, cooking and handyman skills. He goes from nearly complete dependence on the hospital to varied degrees of independence in the community. It was suspected that this "culture shock" may contribute to a high incidence of readmission in this population. The program was developed to reduce this "shock".

Social Learning Theory and Milieu Therapy provide the framework within which the special skills training groups were offered. The program was called The Social Learning Unit, and twelve beds on a 90 bed Acute Psychiatric Unit were set aside for this program's patients. As a patient's condition stabilized and the multidisciplinary team decided he could handle full open ward privileges, he was oriented into the Social Learning Unit. In addition tc regular Rehabilitation Medicine Service (OT, CT) the program included the

following daily skills training classes:

1. Housekeeping
2. Meal Planning and Cooking
3. Money - Management
4. First Aid
5. Medicine Education
6. Anger - Management
7. Leisure Counseling
8. Handyman Skills
9. Relaxation Techniques
10. Music Appreciation
11. Current Events
12. Use of Community Facilities

In addition, there were weekly Discharge Planning Groups and Daily Calisthenics. (See Appendix A). Besides the social reinforcements inherent in such activities, there were concrete, response-contingent consequences for the occurence of adaptive behavior. Participating patients were given points for attendance and participation in their scheduled activities as well as for their general ADL's (See Appendix B). Achievement of approximately 90% of possible points was rewarded by various special activities, such as evening off-ground passes and special trips and privileges. Failure to accumulate a minimum number of points over a period of seven days resulted in reevaluation of the patient's motivation and/or suitability for the program.

The focus of all activities was on the preparation of the patient for life after discharge. The goal of each class was to help develop skills which would be useful to the patient in whatever situation he might encounter in the community. Medication Education Class, for example, not only instructed the patient on the importance of his medication and on the possible side effects, but ultimately led to a trial of self-medication while still on inpatient status. Cooking Class familiarized the patients with balanced nutrition as well as introducing them to basic cooking skills. Anger-Management Class focused on the behavioral expressions of anger and appropriate alternative behaviors.

Community Facilities Class introduced patients to resources available to them in the community (i.e. the Library, shopping malls, Post Office, bowling alleys, laundromats, etc.) and helped to desensitize them to these novel potentially anxiety-causing stimuli. These classes and activities were facilitated through a coordination of the various Medical Center disciplines: Psychology, Social Services, Nursing, Pharmacy, Dietetics, Recreation, RMS, and Psychiatry. An atmosphere of responsibility and independence was encouraged by the physical plant: the program was located entirely and exclusively on the North Porch of the Psychiatric Unit where the patients ate their meals, attended their classes, and were responsible for light housekeeping duties, their lockers (with locker key) and beds. The weekly Community Meetings facilitated communication between patients and staff, and provided patients an avenue for direct input into their treatment.

In addition to the inpatient program, special aftercare opportunities had to be developed. Patients who were to be discharged into the proximal community area and who were appropriate for Day Treatment Center were referred to and involved in Day Treatment Center activities prior to discharge. In addition, it had been noted that there was a group of patients who rejected and/or could not afford placement in the traditional Veteran Administrations' approved community facilities and who preferred a more independent life style. Yet when placed in the community independently, these patients frequently stopped taking medication and failed to attend outpatient appointments, or Day Treatment Center activities. Predictably, after a short time they would exhibit a wide range of inappropriate behaviors including drug and alcohol abuse, poor personal hygiene, sexual promiscuity, verbal and/or physical outbursts

and minor criminal activity which eventually resulted in their readmission. This cycle repeated itself with alarming regularity. It was evident that some support system was necessary to help this subgroup of veterans make the transistion to community life. Thus, a special program was developed in a group of privately owned rooming houses in the community where many veterans in this category were being placed. The landlord was quite receptive to any program we could develop for the veterans in her homes. To stabilize the numerous behavioral crises existing in the home, the following interventions were implemented: All present and potential residents were required to participate in some social, educational or vocational activity outside the home on a regular basis. If they could not find such an activity in the community they were referred to the Canandaigua Veterans Administration Medical Center Day Treatment Center. As frequently as was possible, Social Learning Unit "graduates" were placed in this program.

The Social Learning Unit Social Worker made himself available at any time to all residents within the homes. In addition regular monthly house meetings were started in all the homes, so that residents could discuss with landlord and social worker any problems they may be facing before it became a crisis. Finally to faciliate placement in these homes, a financial plan was developed through the cooperation of County Social Services, Social Security Administration and the Veterans Administration Medical Center Social Service Emergency Fund.

In the first five months of operation of the inpatient Social Learning Unit, a total of 50 patients have actively participated in the program. While detailed data concerning the outcome and effectiveness of the program awaits a longer period of program operation and patient followup, some preliminary data is available. Modal length of stay in the program has been

about three weeks; (range: one week to five months). Modal diagnosis has been Schizophrenia, paranoid type.

The readmission rate of the first 20 patients discharged from the program was compared to that of 20 fully privileged patients who were discharged prior to the institution of the specialized program. The results revealed a 5% readmission rate during the first three months after discharge in program discharges as compared to a 41% readmission rate (13% multiple readmissions) in non-program discharges over a similar three month period. Although not at all conclusive, these statistics are promising.

No objectives data has been compiled as yet on the special aftercare component due to the even smaller sample of patients discharged into it at this time and the brevity of the program. On informal interview, however, all participants report that the program has been very helpful. Community crises have been fewer and readmission rates comparatively lower. Although by no means conclusive, this is suggestive that the program interventions have decreased client behavior crises within the homes and appear to be providing a more supportive environment. However, many more services and programs are certainly needed to help these veterans make the transition to community life and progress to their highest independent functioning level. We hope that this preliminary effort to meet the demand for increased Medical Center turnover rates through life-management skills training, smoother transition mechanisms and supportive aftercare programming provides a solid foundation on which to build.

Appendix A

Schedule of Daily Activities
Social Learning Unit

	Wed.	Thurs	Fri	Sat	Sun	Mon	Tues.
6:00 AM	Wake Up					Wake Up	
6:30 AM	Medication						
7:00 AM	Calisthenics					Calisthenics	
7:30 AM	Point Check					Point Check	
8:00 AM	Breakfast						
8:30 AM	Community Meeting	Med Educ.	Anger Mgmt.			Disch Planning	First Aid
10:30 AM	Occupational Therapy					O.T.	
11:00 AM				Point Check			Nutrition Class
11:30 AM	Medication						
12:00 Noon	Lunch						
12:30 PM		Lunch					
1:00 PM							Community Facilities Group
2:00 PM	Corrective Therapy					C.T.	C.T.
3:00 PM	Current Events	Music Apprec.	Handyman Group			Leisure Counseling	
3:30 PM	Medication						
5:00 PM	Turn In Point Sheets						
5:30 PM	Dinner						
6:00 PM	Evening Passes Begin						
8:30 PM	Medication						
9:30 PM	Relaxation Group						
11:00 PM	Lights Out						
1:00 AM			LIGHTS OUT				

Appendix B

Social Learning Unit Point Sheet

MEDICAL RECORD	PROBLEM ORIENTED FLOW SHEET — GENERAL						
	PROBLEM NUMBERS AND TITLES (Do Not Abbreviate)						
	Wed.	Thurs.	Fri.	Sat.	Sun.	Mon.	Tues.
Getting up on time (2)							
Staying up (4)							
Morning Medication							
Calisthenics (2)							
Appearance	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
Clean fingernails							
Hair combed							
Teeth brushed							
Shaved							
Body clean							
No odor							
All clothing on							
Clothing neat							
Bed made, area neat							
Nothing on floor							
Sheets tucked in							
Blanket neat							
Bedding not soiled							
Locker neat							
Breakfast Attendance							
Clean up							
Morning Meeting	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
Attend				XXXXXXXX	XXXXXXXX		
Prompt				XXXXXXXX	XXXXXXXX		
Attentive				XXXXXXXX	XXXXXXXX		
Active				XXXXXXXX	XXXXXXXX		
	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX

PROBLEM ORIENTED
FLOW SHEET
GENERAL

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MEDICAL RECORD	PROBLEM ORIENTED FLOW SHEET — GENERAL						
	PROBLEM NUMBERS AND TITLES (Do Not Abbreviate)						
	Wed.	Thurs.	Fri.	Sat.	Sun.	Mon.	Tues.
RMS details (2)	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
OT, MAT or IT				XXXXXXXX	XXXXXXXX		
CT				XXXXXXXX	XXXXXXXX		
Swimming				XXXXXXXX	XXXXXXXX		
Jogging				XXXXXXXX	XXXXXXXX		
11:30 Medication							
Lunch - Attend							
Clean-up.							
Afternoon Meeting	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
Attend				XXXXXXXX	XXXXXXXX		
Prompt				XXXXXXXX	XXXXXXXX		
Attentive				XXXXXXXX	XXXXXXXX		
Active				XXXXXXXX	XXXXXXXX		
Community Fac. Grp.	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	
3:30 Medication							
Dinner: Attend							
Clean-up							
Special Activities	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
1.							
2.							
3.							
4.							
5.							
Subtotals							
Evening Medication							
Relaxation Group (2)							

PROBLEM ORIENTED FLOW SHEET GENERAL

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